STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at this facility from January 26, 2017 through February 1, 2017. The facility census the first day of the survey was 115. The survey sample totaled 7 residents which included 4 active and 3 closed records. Abbreviations/definitions used in this report are as follows: NHA- Nursing Home Administrator; DON- Director of Nursing; ADON-Assistant Director of Nursing; MD - Medical Doctor; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; CNA - Certified Nurse's Aide; MDS - Minimum Data Set (standardized assessment forms) used in nursing homes; mg (Milligram) - metric unit of weight, 1 mg equals 0.0035 ounce; SSD-Social Service Director; Cognitive impairment- when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life. Cognitive impairment ranges from mild to severe; Cognitive-process of knowing and understanding; PEG-Percutaneous endoscopic gastrostomy, a tube inserted surgically, most commonly, to provide a means of feeding when oral intake is not adequate; Tracheostomy- a tube is inserted into windpipe to open the restricted airway and enable breathing; Tracheostomy collar-a medical device used to secure a trach tube in its position; Tracheostomy care-involves cleaning the neck	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/24/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 hole, changing the gauze dressing around the tube, keeping breathing air moist, and cleaning and suctioning the tube; Tracheostomy cannula-the outer cannula is the outer tube that holds the tracheostomy open. A neck plate extends from the sides of the outer tube and has holes to attach cloth ties around the neck. The inner cannula fits inside the outer cannula; Tracheostomy suctioning-is the mechanical removal of secretions from the airway to maintain an unobstructed airway, allow for adequate air exchange, and prevent airway infection; Skin prep.- a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction; Pulse oximetry - a test used to measure the oxygen level (oxygen saturation) of the blood. Desired range 94% to 100%; Psychotropic medication: any medication capable of affecting the mind, emotions, and behavior; Sacrum/sacral-large triangular bone at the base of the spine; Anxiety-feeling worry, nervous or restless; Nurses Note (NN)-clinical documentation of care and services provided to the resident by the nurse; Pressure Ulcer (PU)-.sore area of skin that develops when the blood supply to it is cut off due to pressure; Stage II (2) - skin blisters or skin forms an open sore. The area around the sore may be red and irritated.; Braden Scale - tool used to determine risk for development of pressure ulcers; Score of 17 on Braden Scale-moderate risk of developing a PU.	F 000		
F 157	483.10(g)(14) NOTIFY OF CHANGES	F 157		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157 SS=D	Continued From page 2 (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 157	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The physician and the Power of Attorney (POA) for R3 were notified regarding the episodes of anxiety and this resident's self removal of the trach collar, pulling on percutaneous endoscopic gastrostomy (PEG) tube, and repeated removal of her oxygen. R3 has been discharged from the facility and no other corrective action can be completed for this resident. Any resident with a change in condition/status has the potential to be affected. The Administrative Nursing Team will complete a 30 day look back review of the 24 hour report to determine if any resident had a change in condition/status and if proper notification took place. If the physician, legal representative or an interested family member were not notified, they will be notified at that time. Residents with changes in condition will be added to the 24 hour report when changes occur. The 24 hour report will be reviewed in the morning clinical meeting by the Administrative Nursing Team and documentation will be reviewed to ensure proper notification took place with updates at the afternoon clinical meeting. An in-service will be completed for all licensed nurses regarding the regulation pertaining to notification of the physician, legal representative or an interested family member of a change in the resident's status and the documentation required. The DON will audit 5 charts weekly for three months of any resident identified with a change in condition to ensure the physician, legal representative or an interested family member were appropriately notified. Outcomes related to those audits will be reviewed with the steering QAPI committee monthly.	3/27/17

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F 157	Continued From page 3 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to immediately consult with the physician, when R3 experienced a change in condition, in which R3 was restless, anxious and subsequently removed her tracheostomy tube. Findings include: Cross-refer F328. Review of R3's clinical record revealed R3 was admitted to the facility on 12/6/16 and had a tracheostomy and percutaneous endoscopic gastrostomy (PEG). R3 was ordered an anti-anxiety medication, lorazepam, 1 mg. twice a day as needed through the PEG for anxiety. Review of the Nurses Note (NN) dated 12/13/16 and timed 3:30 PM, documented "...(R3) kept removing oxygen mask when awake so anxious (sic) medication for lorazepam but still removed oxygen mask 4 times during the shift, at one time, she removed the inner cannula with speaking valve." The NN ended with "Will pass report." Review of physician's order dated 12/14/16,	F 157	The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 157	Continued From page 4 documented that lorazepam was increased to 1 mg. by PEG, three times a day for indication of anxiety. Review of the Medication Administration Record, from 12/14/16 through 12/16/16 revealed that R3 was administered the lorazepam as ordered The following NNs continued to document R3's anxious behavior: - 12/14/16 by the same 3 PM -11 PM nurse documented R3 removed her oxygen mask 2 times and lorazepam was increased to three times a day for anxiety. - 12/15/16 and timed 3:40 PM documented "...Resident noted with anxiety medicated with lorazepam, removed trach collar twice." - 12/16/16 and timed 9 PM "Resident became very restless and anxious at about 8 PM and lorazepam was administered. Resident pulling on PEG tube and oxygen cannula." Review of the NN dated and timed 12/17/16 and 3:00 PM documented at around 3 PM, Licensed Practical Nurse (E14) went into R3's room and noted that R3 had removed the trach collar and the cannula. R3 verbalized "I took it out, I don't want it." Although R3 continued with multiple episodes of being restless and anxious, after the change in the plan of care on 12/14/16, the facility failed to immediately consult the physician. An interview with E14, on 1/30/17 at approximately 12:45 PM revealed that R3 was restless and anxious during the 7 AM-3 PM shift and E14 closely monitored R3 behavior throughout the shift. E14 verbalized that she	F 157		

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F 157	Continued From page 6 thought she had contacted the physician to report R3's behavior. During the interview, E14 reviewed the R3's facility records and verbalized that it was not completed. An interview with the attending physician (E4) on 2/1/17 at approximately 11:00 AM revealed that if he was consulted, he would have reassessed the current plan of care. Findings reviewed with the Nursing Home Administrator (E1), Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 157		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 166	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The grievance for resident R4 will be documented, investigated, acted upon, and the outcome reported back to the family member per facility policy. E6 was in-serviced regarding the grievance process, including the importance of documenting and following up with any concern reported to them. Any resident voicing a concern has the potential to be affected. The Administrative Team will complete a 30 day look back of the grievances to identify any grievance that has not been fully investigated and resolved and the Social Service Director will address/reassign for completion, any grievance for investigation and resolution as necessary. If a grievance cannot be resolved in three business days, the Administrator is to be notifies so a new deadline can be set.	3/27/17

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F 166	Continued From page 6 of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;	F 166	Grievances will be brought to the Morning Stand-up meeting daily to be reviewed by the Interdisciplinary Team (IDT) and Nursing Home Administrator (NHA) to ensure all grievances are fully investigated and resolved. The Administrative Team will be in-serviced regarding the grievance process and completely investigating and resolving identified concerns. The NHA will audit all grievances for the next three months to ensure completion, full investigation and resolution. Outcomes related to grievances will be reviewed at the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 166	Continued From page 7 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that the facility failed to make prompt efforts to resolve a family's (acting as an agent for the resident) grievance for 1 (R4) out of 7 sampled residents. Findings include: Review of R4's record revealed A review of the facilities policy entitled "Grievance/Concern Management" stated that staff member completes the concern ("Concern Report") form and submits document to the	F 166		

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F 166	Continued From page 8 Social Services Department and or to the Administrative representative. In addition, the Social Services Representative/Risk Manager/Grievance Official brings the concern to the morning meeting to discuss it with the leadership team. An interview with the Office Business Manager (E6), on 1/31/17 at approximately 10 AM, revealed that the family member of R4 had verbalized concerns to E6 regarding care and services provided to R4 on 1/5/17. During this conversation, photographs taken of R4's body by this family member were shown to E6. E6 verbalized that she had brought this verbal complaint to the end of the day daily meeting ("Stand Down Meeting"), in which managers of the departments and the Nursing Home Administrator (E1) were present on 1/5/17. E6 related that she did not document the complaint, although, she did have access to the "Concern Report" form. On 1/31/17 the surveyor requested a copy of the concerns communicated by R4's family member on 1/5/17 from E1. However, the facility failed to have evidence that these concerns from the family member were acted upon. Interview with the Social Service Director (E7) on 2/1/16 at approximately 11:40 AM, who retains the log of grievances/concerns revealed that there was no record of a complaint from R4's family member on 1/5/17. Findings were reviewed with E1, Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 166		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 9	F 225		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that	F 225	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The allegation of abuse of R7 was reported to the Department of Health by the Administrator upon their notification of the allegation. The Shift Supervisor (E9) that failed to report the allegation, was terminated by the facility. The nurse that was accused of the allegation (E) was suspended pending investigation when the Administrator was made aware of the allegation, and was subsequently returned to work and assigned to a different unit. Reportable incidents from the past 60 days were reviewed by the Administrator to ensure all were reported timely. All incidents were determined to be reported within regulation standards. All incidents that are thought to possibly be reportable will be reviewed with the Regional Risk Manager for guidance for reporting. All facility staff regardless of position or title will be in-serviced by the Staff Development Coordinator or designee regarding recognizing and reporting potential allegations of abuse. No staff that has not completed the in-service by the date of compliance will be allowed to work until they have been in-serviced. The Social Worker or designee will complete five interviews per week, of alert and oriented residents, for four weeks to determine If the residents' have any concerns regarding care and treatment. Any concern that is expressed will be investigated and reported per state and federal regulation.	3/27/17

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F 225	Continued From page 10 cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that the facility failed to immediately report an allegation of sexual abuse to the State Agency for 1 (R7) out of 7 sampled residents. Findings include: Review of R7's clinical record revealed Review of R7's Nurses Notes (NN), by assigned Registered Nurse (E8), dated 1/8/17 and timed 9:45 PM documented, "I walked to the nurses	F 225	Results of those interviews and will be reported to the monthly QAPI Committee for review and recommendation. The QAPI committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 225	Continued From page 11 station to give him (R7) his pain medication and overheard him talking to the charge nurse (Registered Nurse, E9) that nurse (E8) is sexually assaulting him by touching him and hugging him." Review of the State Agency's Intake documentation dated 1/23/17, revealed that the facility reported the allegation to the State Agency on 1/23/17 at 5:25 PM. In the incident description section, the facility documented that while reviewing another concern verbalized by R7, the facility's Risk Manager (E11), identified the above allegation. Further review of the facility's investigative file revealed a written statement by a Licensed Practical Nurse (E10) dated 1/23/17, who worked during the 3 PM-11 PM shift on 1/8/17. The statement documented that E10 remembered the conversation at the nurse's station on 1/8/17, in which R7 verbalized to E9, that E8 sexually abused him. Review of the written statement by E8, dated 1/23/17, documented that E9 informed E8 that "he (R7) said you were sexually harassing him." The statement further documented that E9 directed her to just document and tomorrow you can tell someone." An interview with the Nursing Home Administrator (E1), on 2/1/17 at approximately 5:00 PM confirmed that although the above allegation was verbalized to E9 on 1/8/17 by R7, the facility did not report this immediately to the State Agency. Although the allegation of sexual abuse was made on 1/8/17, the facility failed to immediately report the allegation to the SA, failed to initiate	F 225		

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F 225	Continued From page 12 timely investigation, and failed to protect the resident and other residents. The State Agency's intake documentation was dated 1/23/17. Findings reviewed with (E1), Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of	F 226	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The allegation of abuse of R7 was reported to the Department of Health by the Administrator upon their notification of the allegation. The Shift Supervisor (E9) that failed to report the allegation, was terminated by the facility. The nurse that was accused of the allegation (E) was suspended pending investigation when the Administrator was made aware of the allegation, and was subsequently returned to work and assigned to a different unit. Any resident has the potential to be affected. The Social Worker will interview alert and oriented residents to determine if the residents have any concerns regarding care and treatment Any concern that is expressed will be investigated and reported per state and federal regulation. All facility staff regardless of position or title will be in-serviced utilizing CMS Hand in Hand: A Training Series for Nursing Homes Toolkit Module 2 – What is Abuse. This module covers, understanding CMS's definition of abuse, identifying different types of abuse, recognizing abuse, and identifying reporting procedures for abuse and suspicion of a crime.	3/27/17

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F 226	Continued From page 13 resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined that the facility failed to implement their policy and procedure. This failure resulted in lack of immediate reporting of an allegation of sexual abuse to the State Agency, lack of timely investigation, and failure to implement a system to protect R7 and other residents. Findings include: Cross refer F225 Review of R7's record revealed: The facility procedure entitled "Abuse, Neglect, Exploitation, Mistreatment of Resident/Patient, or Misappropriation of Resident/Patient Property", Section Policy", in Section, "Guidelines" documented that "The designated shift supervisor is identified as responsible for immediate initiation of the reporting process" allegation for sexual abuse. In addition, Section, "Protection" documented "Upon identification of actual, suspected or alleged abuse, ...system will be in place to provide for protection of the resident..." Review of R7's Nurses Notes (NN), by assigned Registered Nurse (E8), dated 1/8/17 and timed 9:45 PM documented, "I walked to the nurses station to give him (R7) his pain medication and overheard him (R7) talking to the charge nurse (Shift Supervisor Registered Nurse, E9) that nurse (E8) is sexually assaulting him by touching	F 226	The In-service will also cover the facility policy regarding preventing, recognizing, and reporting abuse. Any staff that has not completed the In-service by the date of compliance will not be allowed to work until the in-service is completed. The CMS Hand in Hand: A Training Series for Nursing Homes Toolkit Module 2 – What is Abuse will be added to the orientation agenda to be utilized upon hire in conjunction with the facility policy regarding preventing, recognizing, and reporting abuse. The facility Administrator or designee will interview 5 staff members per week for the next four weeks regarding the facility policy regarding preventing, recognizing, and reporting abuse to ensure the staff is knowledgeable regarding the policy. The Administrator will follow up with employees as necessary if they are unable to demonstrate knowledge of the policy.Results of those interviews and will be reported to the monthly QAPI Committee for review and recommendation. The QAPI committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 226	Continued From page 14 him and hugging him." Review of the State Agency's Intake documentation dated 1/23/17 revealed that the facility reported this incident to the State Agency (SA) 1/23/17 at 5:25 PM. In the incident description section, the facility documented that while reviewing another concern verbalized by R7, the above allegation of sexual abuse was identified by the facility's Risk Manager (E11) and that E9 failed to immediately report the allegation. An interview with the Nursing Home Administrator (E1) on 2/1/17 at approximately 5 PM confirmed that E9 failed to report the above to the SA immediately. Subsequent interview with E1, on 2/2/17 at approximately 3:55 PM, revealed that E8 was assigned to R7 during the evening shifts on 1/9/17, 1/11/17, 1/12/17, 1/13/17, 1/16/17, 1/17/17, 1/18/17, 1/21/17, 1/22/17, and 1/23/17. Upon E1 being aware of the allegation on 1/23/17, the accused was removed from resident care pending the outcome of the investigation. Although the allegation of sexual abuse was made on 1/8/17 to E9, the facility failed to implement the policies and procedures. The failures included lack of immediate reporting to the SA, timely investigation and the failure to protect the resident and other residents. Findings were reviewed with (E1), Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 226		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 16 (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to provide treatment and services to promote healing of a pressure ulcer (PU) for 1 (R4) out of 7 sampled residents. On 1/1/17, R4 had a new PU, an intact blister of the sacral area and the facility failed to accurately assess the new skin impairment. Findings include: Review of R4's clinical record revealed: Review of R4's "Quarterly/PRN (as needed) Data Collection (With Braden)" completed on 12/3/16 documented that R4 was assessed as "Moderate Risk" for development of new PU with a score of 17. Review of R4's care plan for the risk of developing wound (initial date of 9/23/15 and	F 314	R4 had been discharged to the hospital at the time of the survey and the blister to her sacral area was healed upon her return to the facility, no additional interventions could be completed for this resident. Any area identified upon this resident's return to the facility will be accurately assessed to include location, highest stage (type), length, width, depth, color of drainage, color of wound bed (area), odor and tunneling (going under the edge of the wound) on admission and weekly thereafter until healed. Any resident identified with wounds has the potential to be affected. The Director of Nursing completed and audit of any resident identified with a wound to ensure the Care Plan is being followed in regards to initial and weekly assessments of location, highest stage (type), length, width, depth, color of drainage, color of wound bed (area), odor and tunneling (going under the edge of the wound). The Unit Managers were in-serviced by the Staff Development Coordinator regarding the requirement of a thorough assessment of wounds upon identification and weekly thereafter until resolved to include location, highest stage (type), length, width, depth, color of drainage, color of wound bed (area), odor and tunneling (going under the edge of the wound). The Unit Managers will complete weekly rounds on residents identified with the Wound Team to assess location, highest stage (type), length, width, depth, color of drainage, color of wound bed (area), odor and tunneling (going under the edge of the wound). Results of those assessments will be documented on the weekly skin grid of each resident and recorded on the weekly wound log. The log will be turned in to the Director of Nursing after wound rounds are completed. The Director of Nursing will use the weekly wound log as audit to ensure any resident identified with a wound has he wound assessed per facility policy. These audits will be completed weekly by the Unit Managers and review by the Director of Nursing for 4 weeks then monthly for 3 months. The Director of Nursing will present the results of those audits to be reviewed at the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	3/27/17

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F 314	Continued From page 16 most recent revision date of 12/3/16) due to contributing factors which included incontinence or increased moisture as well as non compliance with the plan of care included the following interventions: -Check skin and turn and reposition every two hours. - Weekly skin assessment. - Pressure reducing support surface to bed. - Monitor meal consumption. Review of the December 2016 Physician's Order Form (POF) Review included the following treatment orders: - weekly skin assessment on Monday 7-3 shift. - turn and reposition every 2 hours every shift. - Skin prep spray -apply to bilateral heels every evening. The quarterly Minimum Data Set (MDS) assessment dated 12/5/16, revealed that R4 was severly cognitively impaired for daily decision making, required extensive assistance of two staff members for bed mobility, extensive assistance of one staff person for transfer, and was incontinent of urine. In addition, R4 did not have a PU, however, was at risk for the development of a PU. Review of the Weekly Skin Assessment documented that there was no new areas of skin impairment on 12/27/16. Certified Nurse's Aide (CNA) documentation, from 12/29/16 through 1/1/17 documented that R4 was turned and repositioned every two hours in addition to checking the skin as ordered. Nurse's Note (NN) dated 1/1/17 and timed 8:12	F 314		

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F 314	Continued From page 17 AM documented that at 5:45 AM on 1/1/17 notified the Nurse of an intact blister on R4's mid sacral area. The NN further documented that both R4's family and the physician were notified of the new skin impairment. Physician's order was obtained for skin prep to be applied to the intact blister located in the mid sacral area every shift until resolved. Review of the Interdisciplinary Team (IDT) note dated 1/3/17, documented that the IDT met related to the blister to the sacral area and that the treatment orders were updated on R4's plan of care. Although R4 had a new intact blister; a stage 2 PU, the facility failed to have evidence that the PU was comprehensively assessed. An interview with Director of Nursing (E2) on 2/1/17 at approximately 10:30 PM revealed that the facility did not have evidence of an assessment of this skin impairment which was identified as an intact blister on 1/1/17 in the sacral area. Findings reviewed with Administrator (E1), E2, and Regional Corporate Nurse (E6) on 2/1/17 at approximately 5:30 PM.	F 314		
F 328 S6=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance	F 328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 328	Continued From page 18 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the	F 328	R3 has been discharged from the facility and no other corrective action can be completed for this resident. An audit will be completed by the Interdisciplinary team of any resident identified with an acute change in condition in the past 48 hours received close monitoring as necessary and will educate nursing staff and implement monitoring as necessary. The licensed nurses will be educated utilizing the INTERACT Protocols for assessment and documentation, and regarding what types of changes in condition require close monitoring until 1) the condition resolves or 2) emergency personnel arrive. The 24 hour report along with the corresponding Nursing Notes will be reviewed in the daily Clinical Meeting to determine if change in condition occurred, if the change required close monitoring, and if the monitoring occurred and documented as necessary. Licensed nurses will be followed up with as necessary. The Director of Nursing will utilize that 24 hour report review as an audit determine if change in condition occurred, if the change required close monitoring, and if the monitoring occurred and was documented as necessary, and determine if further education is necessary. The audits will be completed daily Monday through Friday for two months.The Director of Nursing will present the results of those audits to be reviewed at the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	3/27/17

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F 328	Continued From page 19 residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that 1 (R3) out of 7 sampled residents received the necessary care and services related to her tracheostomy. R3 had a tracheostomy tube and pulled out the tracheostomy on 12/17/16. The facility failed to closely monitor R3's respiratory status while awaiting for the ambulance. Findings include: Review of R3's clinical record revealed R3 was admitted to the facility on 12/6/16 from the hospital and review of the admission orders dated 12/6/16 included the following: - lorazepam (medication to treat anxiety) 1 mg. via percutaneous endoscopic gastrostomy (PEG) tube two times as needed a day for anxiety. - check pulse ox (pulse oximetry) every shift. - oxygen at 5 liters per minute via tracheostomy mask. - tracheostomy care every shift and as needed. - suction every shift and as needed. - change tracheostomy collar twice a week. R3's care plan included "Breathing problems related to tracheostomy..." Goal included to will	F 328		

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F 328	Continued From page 20	F 328		

be free of shortness of breath and minimize anxiety. Interventions included to monitor for changes in or development of signs and symptoms of breathing difficulty and report including change in cognition; suction as needed and to report changes in respiratory status to physician.

Review of the Treatment Administration Record (TAR), from 12/6/16 through 12/13/16 revealed the following:
- pulse oximetry ranged from 95 % to 98%.
- tracheostomy care completed every shift and as needed, as ordered.
- suctioning every shift and as needed, as ordered.

The admission Minimum Data Set (MDS) assessment dated 12/13/16, revealed that R3 was severely cognitively impaired for daily decision making, required extensive assistance of two staff members for bed mobility, toilet use, and personal hygiene.

Review of Nurses Notes (NN) from 12/13/16 through 12/16/16 documented that R3 was restless and anxious and was removing her oxygen mask, removing the inner cannula of the tracheostomy and adjustments were being made to R3's anti-anxiety medication, lorazepam.

Additional review of the TAR, from 12/14/16 through 12/16/16 revealed that R3's pulse oximetry continued to range between 95 % to 98%, as well as tracheostomy care and suctioning was documented as completed.

Review of the NN dated and timed 12/17/16 and 3:00 PM, by Licensed Practical Nurse (E14)

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F 328	Continued From page 21 documented at around 3 PM, E14 went into the room and noted that R3 had removed the tracheostomy collar and the cannula. R3 verbalized, "I took it out, I don't want it." Supervisor was notified and vital signs obtained with pulse oximetry of 83%. The NN further documented that physician was contacted and an order to send R3 to the hospital. R3 departed the facility at 4:00 PM. Although a pulse oximetry was obtained, record review lacked evidence of close monitoring of R3's condition, including repeat respiratory reassessment with pulse oximetry prior to the arrival of the ambulance. Review of the ambulance records dated 12/17/16 documented at 4:06 PM, the pulse oximetry was 87%. Emergency room records dated 12/17/16 documented that a replacement tracheostomy was inserted and R3's oxygenation improved and R3 was discharged back to the facility on 12/17/16 at 10:20 PM. An interview with E14 on 1/30/17 at approximately 12:45 PM revealed that R3 was restless during the 7 AM-3 PM shift and E14 was closely monitoring R3's behavior. At 3:00 PM on 12/17/16, E14 observed the tracheostomy collar and the cannula laying on R3's chest. E14 verbalized that she had completed a set of vital signs including pulse oximetry before starting to administer the oxygen, which was 83%. E14 verbalized while administering oxygen, E14 was monitoring R3, however, was not able to recall any additional R3's respiratory status, including a repeat pulse oximetry to assess the effectiveness	F 328		

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F 328	Continued From page 22 of the oxygen intervention. An interview with the attending physician (E4) on 2/1/14 at approximately 11:00 AM revealed that a respiratory reassessment including a pulse oximetry would have beneficial to assess the effectiveness of the oxygen administration. Findings reviewed with Nursing Home Administrator (E1), Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 328		
F 329	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 329	R3 has been discharged from the facility and no other corrective action can be completed for this resident. A list of residents receiving anti-anxiety medication was provided by the pharmacy and the medical record was reviewed to verify the residents were being monitored for targeted behaviors, monitored for effectiveness of pharmacological intervention, monitor for side effects, and reassess the interventions.Any resident receiving psychotropic medications will be reviewed monthly by the Interdisciplinary Team (IDT) to ensure behavior monitoring is in place for targeted behaviors, the resident is monitored for effectiveness of pharmacological intervention, monitored for side effects, and interventions are reassessed. The IDT will work with Psychiatric Services regarding medication adjustments and gradual dose reductions. The licensed nurses were in-serviced by the Staff Development Coordinator regarding the requirement of monitoring for targeted behaviors, monitoring for effectiveness of pharmacological intervention, monitoring for side effects, reassessment of the interventions, and the importance of documenting the above. The IDT will audit 5 medical records weekly of residents receiving anti-anxiety medications for 4 weeks then monthly for 3 months to ensure monitoring is in place for targeted behaviors, the resident is monitored for effectiveness of pharmacological intervention, monitored for side effects, the interventions are reassessed, medications are adjusted as necessary and gradual dose reductions are attempted as appropriate..	3/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

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F 329	Continued From page 23 determined that for 1 (R3) out of 7 sampled residents the facility failed to ensure adequate monitoring of psychotropic medication. R3 had a target behavior of anxiety. The facility failed to monitor the targeted behavior, monitor the effectiveness of the pharmacological intervention, and failed to monitor the side effects. Due to these failures, the facility failed to reassess the interventions, resulting in the resident becoming increasingly anxious and restless and R3 pulling out her tracheostomy tube and requiring replacement of the tracheostomy in the hospital. Findings include: Review of R3's clinical record revealed R3 was admitted to the facility on 12/6/16 from the hospital and review of the admission orders dated 12/6/16 included the following order for an anti-anxiety medication, lorazepam 1 mg. via a feeding tube, two times as needed a day for anxiety. Review of R3's Plan of Care initiated 12/13/16, revealed the following: - "Use of psychotropic drug, anti-anxiety for diagnosis of anxiety. A goals included to decrease anxiousness episodes to "0" as well as to improve sleep to 8 hours per night. Interventions included to report to physician negative outcomes associated with use of drug; monitor for effectiveness of psychotropic drug; attempt to promote sleep prior to medication administration. - "Breathing problems related to tracheostomy..." Goal included to will be free of shortness of breath and to minimize anxiety. Interventions included to monitor for changes in/or development of signs and symptoms of breathing	F 329	The Director of Nursing will present the results of those audits to be reviewed at the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations	

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F 329	Continued From page 24 difficulty and report including change in cognition; suction as needed and to report changes in respiratory status to physician. The admission Minimum Data Set (MDS) assessment dated 12/13/16, revealed that R3 was severely cognitively impaired for daily decision making, required extensive assistance of two staff members for bed mobility, toilet use, and personal hygiene. Nurses Note (NN) dated 12/13/16 and timed 3:30 PM documented "...kept removing oxygen mask when awake so anxious medication for lorazepam but still removed oxygen mask 4 times during the shift, at one time, she removed the inner cannula with speaking valve." The NN ended with "Will pass report." Review of the Medication Administration Record (MAR) on 12/13/16 revealed that R3 was administered the lorazepam on 12/13/16 at 9:05 AM and this was not effective, as documented in the NN that R1 continued to remove her oxygen mask 4 more times. Record review lacked evidence that the facility was monitoring the potential effectiveness/side effects of the medication. Physician's order dated 12/14/16 documented that lorazepam was increased to 1 mg. to be administered through R3's feeding tube three times a day for indication of anxiety. Additional review of the MAR, from 12/14/16 through 12/16/16 revealed that R3 was administered the anti-anxiety medication as ordered, however, record review lacked evidence of monitoring the effectiveness of such	F 329		

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F 329	Continued From page 25 intervention and side effects. The following NN continued to document R3's anxious behavior: - 12/14/16 by the same 3 PM -11 PM nurse documented R3 removed her oxygen mask 2 times and lorazepam was increased to three times a day for anxiety. - 12/15/16 and timed 3:40 PM documented "...Resident noted with anxiety, medicated with lorazepam, removed trach collar twice. - 12/16/16 and timed 9 PM "Resident became very restless and anxious at about 8 PM and lorazepam was administered. Resident pulling on PEG tube and oxygen cannula." Although R3 continued to exhibit the targeted behaviors of anxiety, as evidenced by the above NNs, record review lacked evidence that the facility had a system to monitor the occurrence of the targeted behavior, the outcome of the intervention, and the presence of the effectiveness/side effects of lorazepam Findings reviewed with Nursing Home Administrator (E1), Director of Nursing (E2), and Regional Corporate Nurse (E5) on 2/1/17 at approximately 5:30 PM.	F 329		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Rehabilitation Center

DATE SURVEY COMPLETED: February 01, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint survey was conducted at this facility from January 26, 2017 through February 01, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115 The survey sample totaled 7 Residents.		3/27/17
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer Cross refer to the CMS 2567-L survey completed January 01, 2017: F0157, F0166, F0225, F0226, F0314, F0328, F0329		

Provider's Signature _____ Title Administrator Date 3/24/17